

**STATE OF CONNECTICUT**  
**GENERAL ASSISTANCE RECOVERY SUPPORTS PROGRAM (GA RSP)**  
Department of Mental Health & Addiction Services

**Provider Assessment and Request Form (ARF)**

FAX TO: 1-866-249-8766

APPLICANT'S NAME: \_\_\_\_\_ EMS#: \_\_\_\_\_

**INITIAL ELIGIBILITY REQUIREMENTS**

**Applicant must:**

- be actively receiving SAGA Medical; and
- not be receiving cash assistance or any other income; and
- be actively engaged in behavioral health treatment; and
- be in need of recovery supports not met by existing or available resources.

\*Applicants are required to submit evidence of job search, vocational training, or employment readiness services to maintain ongoing eligibility.

**APPLICANT INFORMATION**

APPLICANT ADDRESS/LIVING SITUATION: \_\_\_\_\_

ADDRESS CONTINUED: \_\_\_\_\_

APPLICANT PHONE #: \_\_\_\_\_ APPLICANT SS#: \_\_\_\_\_

**Currently or in the past, has the applicant been involved with the criminal justice system (e.g. arrest history, incarceration, probation, parole, etc.)** Yes \_\_\_\_\_ or No \_\_\_\_\_

**TREATMENT PROVIDER INFORMATION**

Please indicate what services you are providing:

\_\_\_\_ MENTAL HEALTH      \_\_\_\_ SUBSTANCE ABUSE      \_\_\_\_ CO-OCCURRING

NAME OF TREATMENT PROGRAM: \_\_\_\_\_

TREATMENT PROGRAM ADDRESS: \_\_\_\_\_

PROGRAM PHONE #: \_\_\_\_\_ PROGRAM FAX #: \_\_\_\_\_

DATE OF ADMISSION: \_\_\_\_\_ LEVEL OF CARE: \_\_\_\_\_

ANTICIPATED DATE OF DISCHARGE: \_\_\_\_\_

TOWN DESTINATION AFTER DISCHARGE: \_\_\_\_\_

**Based on the applicant's engagement/participation in treatment, would you advocate for the approval of GA RSP services?** YES \_\_\_\_\_ or NO \_\_\_\_\_

TREATMENT PROVIDER NAME (please print): \_\_\_\_\_

TREATMENT PROVIDER'S SIGNATURE: \_\_\_\_\_

APPLICANT'S SIGNATURE: \_\_\_\_\_

DATE FORM COMPLETED: \_\_\_\_\_

APPLICANT'S NAME: \_\_\_\_\_

**REQUESTED RECOVERY SUPPORTS**

**INDEPENDENT HOUSING-** *A completed Landlord Verification Form and copy of your current Lease must be submitted. For payment a completed W9 form from the landlord must be received by ABH.*

Owner Name and Address: \_\_\_\_\_

Rental Address: \_\_\_\_\_

Amount Requesting: Monthly Rent: \_\_\_\_\_ Time Period: \_\_\_\_\_

Security Deposit: \_\_\_\_\_ Move-in Date: \_\_\_\_\_

**SUPPORTED RECOVERY HOUSING SERVICES-** *Requested site must be a certified and contracted GA RSP vendor.*

Vendor Name: \_\_\_\_\_ Time Period: \_\_\_\_\_

Site Address: \_\_\_\_\_

**SHELTER HOUSING SERVICES-** *Requested site must be a certified and contracted GA RSP vendor.*

Vendor Name: \_\_\_\_\_ Time Period: \_\_\_\_\_

Site Address: \_\_\_\_\_

**UTILITIES-** *A current copy of the utility bill in the applicant's name is required. Applicant must provide documentation that energy assistance is being used or has been exhausted.*

1. Utility Vendor: \_\_\_\_\_

Amount Requesting: \_\_\_\_\_ Account Number: \_\_\_\_\_

2. Utility Vendor: \_\_\_\_\_

Amount Requesting: \_\_\_\_\_ Account Number: \_\_\_\_\_

**FOOD**

Vendor Name and Address: \_\_\_\_\_

Amount Requesting: \_\_\_\_\_

**PERSONAL CARE/HAIR CUT**

Vendor Name and Address: \_\_\_\_\_

Amount Requesting: \_\_\_\_\_

**CLOTHING**

Vendor Name and Address: \_\_\_\_\_

Amount Requesting: \_\_\_\_\_

**OTHER –** *Supporting documentation must be submitted along with the explanation of the request.*

Explanation of other items applicant may need and why: \_\_\_\_\_

Vendor Name and Address: \_\_\_\_\_

Amount Requesting: \_\_\_\_\_

**TRANSPORTATION-** *If transportation is to be provided by a livery service, the transportation supplement needs to be completed.*

Vendor Name and Address: \_\_\_\_\_

Amount Requesting: \_\_\_\_\_





# Department of Mental Health and Addiction Services (DMHAS) General Assistance Recovery Supports Program

## Consent to Disclosure and Re-disclosure of Confidential Information and Records

I, \_\_\_\_\_, DOB: \_\_\_\_\_,  
(Name of Participant) (Date of Birth)

EMS# \_\_\_\_\_, SS# \_\_\_\_\_ as a  
(EMS Number) (Social Security Number)

participant in the DMHAS General Assistance Recovery Supports Program, understand my treatment and support services will be coordinated through DMHAS and the DMHAS designated Administrative Service Organization (ASO). I authorize the following individuals and organizations to release and exchange information to each other for the purpose of processing General Assistance Recovery Supports Program requests:

1. The DMHAS Administrative Service Organization; and
2. \_\_\_\_\_  
*[Referring Treatment Provider/Program]*
3. \_\_\_\_\_  
*[Requested Service Vendor(s)]*

This information may include: my name, address, age, gender, Social Security Number, clinical assessment, progress in care, the type and outcome of mental health and addiction services I have received/am currently receiving, General Assistance Recovery Supports Program history and such other information as is necessary to provide effective coordination of the treatment and services I receive.

The purpose of the disclosure authorized herein is to facilitate the provision of General Assistance Recovery Supports Program services.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2 and Chapter 899 of the Connecticut General Statutes, and cannot be disclosed without my written consent unless otherwise provided for in the regulations or statutes. I have received a summary of the federal law protecting this information and a statement of the intended use of this information. I understand that the federal regulations restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient, and I understand that the rules prohibiting re-disclosure to third parties without my written consent will be strictly adhered to. I also understand that I may revoke this at any time except to the extent that action has been taken in reliance on it. Unless revoked by me, this consent shall expire upon completion of this application, or:

\_\_\_\_\_  
*[Specific date, event or condition upon which this consent expires, only if different from above]*

Date: \_\_\_\_\_  
*[Signature of Participant]*

\_\_\_\_\_  
*[Signature of parent, guardian or authorized representative where required]*

This notice accompanies a disclosure of information concerning a client in alcohol/drug abuse treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Landlord Verification Form to be given to housing vendors for completion.

# General Assistance Recovery Supports Program (GA RSP)

## Landlord Verification Form

The State of Connecticut has contracted with Advanced Behavioral Health to provide basic housing support payments for eligible GA RSP program participants who are in need of some assistance, and whom have no other means of payment.

Under the terms of the contract with the State of Connecticut, cash payments cannot be made to program participants. Therefore, a system to subsidize emergency basic needs payments for rental assistance by paying the vendor directly has been established.

**A 1099-MIS will be sent to you at the end of the year for any rental income paid for this program participant.**

**RENTAL ASSISTANCE FOR PROGRAM PARTICIPANTS CAN ONLY BE PAID DIRECTLY TO PROPERTY OWNERS.**

To expedite processing of this request, please complete the landlord section of this form and either mail or fax to:

Advanced Behavioral Health  
General Assistance Recovery Supports Program (GA RSP)  
PO Box 735  
Middletown, CT 06457

Telephone #: 1-800-658-4472  
Fax #: 1-866-249-8766

The program participant will be informed whether or not the request has been approved. If the request is approved, a letter will follow to you, **with a W-9 to be completed and sent to Advanced Behavioral Health**. Upon receipt of the completed W-9 form Advanced Behavioral Health will issue **payment within 30 days**.

\_\_\_\_\_ Has indicated that he/she will be residing at:  
(Name of program participant)

\_\_\_\_\_ Monthly/Weekly Rent: \$ \_\_\_\_\_  
(Address participant is/will be residing) Security Deposit: \$ \_\_\_\_\_

Name of Owner: \_\_\_\_\_

Owner Address: \_\_\_\_\_

Owner Telephone #: \_\_\_\_\_ Owner FEIN / SSN: \_\_\_\_\_

Length of time program participant has been residing at above address or anticipated move-in date? \_\_\_\_\_

**Please forward a copy of the lease with this verification form.**

Structure Type (e.g. single family house, multifamily house, apartment building, condo, etc.) \_\_\_\_\_

Unit Type (private apartment, shared apartment/house, sober house, room, etc.): \_\_\_\_\_

Number of bedrooms in the unit: \_\_\_\_\_

What is the maximum allowable occupancy of the dwelling or unit, per local zoning regulations? \_\_\_\_\_

How many people live in this household, per the lease agreement? \_\_\_\_\_

Are all household members related? Y/N If not, how many unrelated people live in this household? \_\_\_\_\_

Please list all residents permitted to use this unit:

\_\_\_\_\_  
\_\_\_\_\_

Please check any of the following that are included in the rent:

Heat  Electricity  Gas  Oil  Hot Water  Meals  Other \_\_\_\_\_

Signature of Owner: \_\_\_\_\_ Date: \_\_\_\_\_

**By signing this form, I understand that I am attesting to the truth of the information above, including compliance with local zoning regulations. I further understand that this information is subject to verification and audit, and that intentional misrepresentation may lead to criminal prosecution.**

# General Assistance Recovery Supports Program (GA RSP)

## JOB READINESS INFORMATION

APPLICANT'S NAME: \_\_\_\_\_

Please include information explaining job readiness efforts. This may include job searches, vocational training, posting resumes online, treatment related employment groups, online education, etc.

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List all job search contacts:

	Date	Company & Position	Contact Person & Phone #	Type of Contact <i>i.e.: Sent resume or interviewed</i>
1				
2				
3				
4				
5				

List all vocational training contacts:

	Date	Type of Training	Contact Person & Phone #	Dates of Training
1				
2				
3				
4				
5				

# General Assistance Recovery Supports Program (GA RSP)

## Livery Transportation Supplement

### INSTRUCTIONS TO TREATMENT PROVIDER:

1. Complete this form along with:

- Contacting the livery vendor, Road To Recovery at 203-401-2088, directly to make arrangements for transportation services 24 hours prior to the service;
- Page 1 and 2 of the GA RSP Provider Assessment and Request Form (ARF); and
- A GA RSP Release of Information Form

2. Fax **ALL** of the above documents to Advanced Behavioral Health (1-866-249-8766) **24 hours prior to transport**

- ABH will fax a determination page back indicating whether the transport has been authorized and what amount will be allowed
- Please sign the transportation supplement and return to the livery driver upon pick-up. (Livery vendors cannot provide transportation without this signature).

**Applicant Name:** \_\_\_\_\_ **EMS#:** \_\_\_\_\_

**Date of Transport:** \_\_\_\_\_

**Origin Agency:** \_\_\_\_\_

**Origin City:** \_\_\_\_\_

**Origin Agency Signature (on date of transport):** \_\_\_\_\_

**Date Signed:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**Destination Agency:** \_\_\_\_\_

**Destination City:** \_\_\_\_\_

**Destination Agency Signature (on date of transport):** \_\_\_\_\_

**Date Signed:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**Number of Miles:** \_\_\_\_\_

**@ \$2.60 per mile:** \_\_\_\_\_

**Service Fee:** \_\_\_\_\_ **\$12.00**

**Total Requested:** \_\_\_\_\_